CONFIDENTIAL REPORT OF WORK-RELATED HOSPITALIZED BURNS

Safety & Health Assessment & Research for Prevention (SHARP)
Department of Labor & Industries
PO Box 44330, Olympia WA 98504-4330
Phone: 360-902-5669 Fax: 360-902-5672

PLEASE PRINT OR TYPE
Please photocopy this form if you need additional forms.
Return completed form to SHARP.

Name of Person Submitting Report

Reporting Date (mm/dd/yyyy)	Phone Number of Person Submitting Report

Patient's Name (Last, First, Middle)

Patient's Address | City | State | Zip Code

Patient's Phone Number	Patient's Date of Birth (mm/dd/yyy)	Patient's Age	Patient's Sex ❑ M ❑ F

Patient's Occupation	Patient's Employer (Include Company Name, City and State)

Place of Injury
❑ Employer's Premises (Listed Above) ❑ Other, Please Specify:

Description of Injury/Accident

Burn Source (e.g., Hot Water, Hydrofluoric Acid, Electrical Wire, etc.)

Description of Body Parts (Check All That Apply)
❑ Hands, Fingers, Wrist ❑ Head, Face, Neck ❑ Upper Extremity ❑ Lower Extremity ❑ Trunk
❑ Eyes ❑ Internal ❑ Multiple ❑ Other, Please Specify:

Degree of Burn ❑ 1st Degree ❑ 2nd Degree ❑ 3rd Degree ❑ Deep 3rd Degree, With Loss of Body Part	Total Body Surface Area (%)

Burn Type
❑ Thermal ❑ Chemical ❑ Electrical ❑ Radiation ❑ Friction ❑ Other, Please Specify:

Date of Injury (mm/dd/yyyy)	Date of Admission (mm/dd/yyyy)
Diagnosing Physician's Name	Diagnosing Physician's Specialty

Diagnosing Physician's Address | City | State | Zip Code

Diagnosing Physician's Phone Number

Thank you for your time submitting this case report!